Preparing for ICD-10:
Are You Ready for Implementation?
It’s Not Too Late.

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• Today’s presentation is informational only - no credit available.

Sharon Roeder, CPC
Manager of Payer Coding Compliance, vRad
June 18, 2015

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Welcome

After you leave the session, a web page will appear where you can:

Preparing for ICD-10-CM
Are You Ready for Implementation?
It’s Not Too Late.

Sharon Roeder, CPC
Manager of Payer Coding Compliance, vRad
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Disclaimer

• This presentation is designed to provide participants with reimbursement and coding related news, updates and guidance.

• The materials and documents presented are not intended to supersede any policies, procedures, or templates that vRad or your facility has approved and implemented, unless specifically noted.

• The information, while accurate, to the best of our knowledge, at the time of production, may not be current at the time of use.

• Information is provided as general guidance only and is not a recommendation for a specific situation. Viewers should consult official sources (CMS, ACR, AMA) or a qualified attorney for specific legal guidance.

• Information provided is based on Medicare Part B billing guidelines and may or may not pertain to Medicare Part A billing. Viewers should consult their Part A – Medicare Administrative Contractor website for hospital billing guidelines.

Our Agenda

• It’s not too late to take proactive action

• Be smart and focus your final push on areas where the results will have the largest positive impact

• Strategies for gathering clinical details from referring physicians and departments

• Training key staff and radiologists

• Documentation tool examples
“ICD-10 is a greatly intuitive system. If we know stuff about our patient, there’s probably a code for it. Describe the patient’s symptoms or diseases as you’d talk about them with a family member or with your office manager. Identify the cause of a disease and identify the effects of that disease on other body parts. And there are codes for most of these. Not a big deal.”

Dr. Roberts S. Gold, M.D.
AAPC Tips & Resources
Issue 58, April 10, 2015

Dr. Gold is founder of DCBA, Inc. which is a consulting company in Atlanta that provides physician-to-physician education for documentation improvement programs nationwide.

Tell the Story

Location:
- Specific anatomical site
- Laterality / Quadrants / proximal or distal

Context:
- Timing: Onset date / duration /recurring / active treatment, during healing phase, or due to complication
- Injury: is the exam to help with diagnostic or treatment decisions OR is exam to evaluate healing process?
- Cause(s) of the symptoms or condition
- Chronic, acute, transient?
- Severity of the symptoms/condition
- Stage, status, or type of the disease

Associated or Concurrent Condition:
- Existing disease/condition that contribute to the symptoms/condition
- Pregnant? (Start date of the Last Menstrual Period)
- Medical history pertinent to exam (personal /family)
“How can we provide clinical details on our orders and radiology reports if the referring physician does not provide us with detailed indications? This is out of our control!”

There are only 104 days left to prepare!

Have you resigned your fate to your referring physicians?

How are you going to take control of getting more specific clinical details from your referring resources?

It is not too late!
The radiologist does not necessarily have a face-to-face interaction with the patient. The radiologist must rely on the referring physician and the technologist who is performing the exam to provide the patient’s story. Therefore, the story must be included in both the orders and final report.
From the Order to the Claim

Ordering Physician
- Identify top referring physicians and those submitting a high volume of non-specific indications
- Communicate and educate
- Update order forms that ask probing questions

Scheduler
- Education focusing on additional details that are needed from referring physicians
- Create tools or scripts on what to ask the referring physicians
- Ask patients to complete medical information forms at check-in

Technologist
- Empower to ask the patient "What brought you in for today's radiologic exam?"
- Review "medical information forms" and ask additional questions for complete information
- Archive or record the patient’s answer in the RIS or other medical record system

Radiologist
- Dictate detailed, pertinent finding(s) in the final report
- When the exam is normal, dictate the "reason for the exam" details

Billing Coder
- Select the pertinent finding for the primary diagnosis
- In absence of positive findings, select the pertinent reason for the exam for the primary diagnosis
- Look for diagnostic details in the body of the report

Now is the time to start educating and training all pertinent players!

Ordering Physicians

Ordering Physician
- Identify top referring physicians and those submitting a high volume of non-specific indications
- Communicate and educate
- Update order forms that ask probing questions

- Identify highest volume of procedures and associated billed ICD-9 codes
  - Identify non-specific codes
  - Identify what documentation is lacking for ICD-10

- Create an inventory of physicians who refer a high-volume of patients
  - Identify those providing a high-volume of non-specific indications
  - Identify those providing non-specific indications, such as “rule-out”

- Don’t forget the Emergency Room as a referring source

- Communicate with these referring physicians now and after October 1
Step 1: Focus on High Volume Non-specific Codes

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Volume</th>
<th>Code Description</th>
<th>Additional Clinical Information for ICD-10-CM</th>
</tr>
</thead>
</table>
| 786.50             | 48,707  | Chest pain, unspecified                       | LOCATION: chest wall, intercostal, precordial  
CONTEXT: On respiration, cause of pain  
CONCURRENT CONDITION: COPD, Cancer (type)                                                 |
| 793.19             | 45,490  | Other nonspecific abnormal finding of lung field | LOCATION: Rt, Lt, superior, middle, or inferior lobe  
CONTEXT: Nodule, shadow, associated symptoms  
CONCURRENT CONDITION: COPD, Cancer (type)                                                  |
| V71.4              | 45,482  | Encounter for examination following other accident | LOCATION: Anatomical location of the injury  
CONTEXT: Type of injury, how & where injured, sx  
CONCURRENT CONDITION: HIV, pregnant                                                        |
| 511.9              | 42,354  | Pleural effusion, not specified               | LOCATION: known (pleural)  
CONTEXT: Symptoms, recurrent, onset  
CONCURRENT CONDITION: Cancer (type), CHF, TB, Lupus, Influenza or pneumonia, ESRD, Cirrhosis or liver disease |

Analyze Code Volumes by Procedure

CPT CODE 73510  
X-ray of the Hip, unilateral

<table>
<thead>
<tr>
<th>Billed ICD-9</th>
<th>Volume</th>
<th>Diagnostic Code Description</th>
<th>Additional Clinical Information for ICD-10-CM</th>
</tr>
</thead>
</table>
| 719.45       | 3041   | Pain in pelvic joint                                      | LOCATION: Laterality  
CONTEXT: other symptoms (fever), timing, acute, chronic  
CONCURRENT CONDITIONS: Hip prosthesis, post-trauma                                              |
| V71.4        | 487    | Observation for suspected condition                       | What symptoms raise suspicion for this condition?                                                             |
| 715.95       | 468    | Osteoarthrosis of the pelvic region, NOS                 | LOCATION: Laterality  
CONTEXT: Primary or post-trauma  
CONCURRENT CONDITIONS: Hip dysplasia or prosthesis                                                  |
| 959.6        | 408    | Injury to hip and thigh, not specified                    | LOCATION: Hip or thigh? Muscle or tendon? Laterality?  
CONTEXT: Type of injury (strain, contusion, puncture wound, foreign body), symptoms, or unconscious. TIMING: Initial, follow-up, sequela  
CONCURRENT CONDITIONS: Pregnant (LMP for trimester and gestation)                                    |

*These claims were denied due to medical necessity

TIP: Focus on top volume codes for:
- Communications to referring physicians
- Training for internal staff
- Redesigning referral or order forms to capture detailed indications
Sample Letter to Your Referring Physicians

Dear Dr. Jones,

The implementation deadline for ICD-10 is rapidly approaching. The new code set requires a higher degree of specificity in order to improve clinical outcomes and documentation. [Sender's facility] currently receives a high volume of non-specific indications from referring physicians. As we transition into ICD-10, we will be requesting more clinical detail (as well as ICD-10 codes) on the referral orders you send to us.

When ordering a study, consider including these additional details for the reason for the exam:

- **Location**: Please provide the specific anatomical location of the symptoms or condition (laterality, proximal or distal, quadrant, part of the lung, specific part of the bone, etc.).
- **Context**: Please include clinical information that provides context or explains “who, what, when, where, why, and how.”
- **Associated or concurrent conditions**: Please state if there are any underlying or related diseases, or medical history, that is pertinent to the reason for exam. If the patient is pregnant, include the first day of their last menstrual period (LMP).
- **Injuries**: Please provide the date of the injury. It is helpful for us to understand if you are seeking a diagnostic interpretation for treatment decisions, status on the healing process, or an evaluation of a residual problem.

Providing this additional clinical information will allow us to provide better care and assessment or your patient. Please feel free to contact me with any questions.

Redesigning Order Forms

One generic order form will not work effectively for ICD-10.

Devote more space for collecting procedure and clinical details.

One Size Does Not Fit All
ICD-10-CM Code vs Clinical Descriptive Information?

- Will the ICD-10-CM code you receive be documented in the legal medical record?

- Code selection varies amongst coders, even some selecting inaccurate codes. That inaccuracy rate will likely increase with ICD-10-CM.

- Do you know who is selecting the ICD-10-CM code? Is it the ordering physician, a nurse, a scheduler, or a coder who has ICD-10-CM proficiency certification?

- Are you willing to trust somebody else providing an accurate code? Keep in mind, the billing provider is responsible for appropriate services for appropriate medical reasons.

- If you don’t receive clinical information, how can you confirm the ICD-10-CM code?

Start NOW

- Evaluate order systems and forms

Trash this one! But keep LMP

Adding History is helpful but you don’t need a full history, only relevant history

Staging adds context
Start NOW

- Evaluate order forms.

- Ask more specific, leading questions versus providing a free text area.
- Provide scheduling tools to front desk staff taking orders by telephone.
- Consider basing order forms and tools on the study ordered.

Where to Focus?

- Referring physicians:
  - Revamp order forms
  - Request patient medical records, e.g. history and physician exam notes
  - Canned questions for the schedulers to ask (general and specific to top-ordered procedures)

- Emergency room
  - How will your radiology department get the information from the ER?
  - Gather the clinical details after the exam?
  - Collaborate with ER management staff

- Patient and/or caregiver:
  - Check-in: Symptom and history forms
  - Empower technologists to interview and document patient’s chief complaints!
Patient and Caregivers

Create check-in forms to gather details of the patient’s chief complaint and history.

General form vs. specific forms for high volume procedures?

WHAT BRINGS YOU TO OUR OFFICE?

FIRST COMPLAINT:
• Date when symptom first appeared
• Did it begin Gradual Sudden Progressive over time
• What makes the symptoms increase?
• What relieves the symptoms?
• Type of Pain Sharp Dull Ache Burn Throb
• Does the Pain Radiate into your Arm Leg Does not radiate
• Do you experience Numbness or Tingling? Y N
• How often do you experience these symptoms?
  100% 75% 50% 25% 10%
• PAIN INTENSITY? Please put line on the scale describing the intensity of your pain.
  No Pain 1 2 3 4 5 6 7 8 9 10

Revamp Current Forms and Worksheets

What missing details could be added to this Mammogram Worksheet?

Most of these indications require laterality

Expand Implant Section:
1. Current implant or history of implant removal?
2. What type of problem?
Schedulers

- Education focusing on additional details that are needed from referring physicians
- Create tools or scripts on what to ask the referring physicians
- Ask patients to complete medical information forms at check-in

- Focus training on high volume procedures and frequently used diagnoses.
- Consider Medical Terminology and Anatomy 101 training. (KISS)
- Create canned questions to ask when scheduling exams by phone.
- Specific questions by procedures:

  We create specific prep instructions by exam type, why not scheduling questions to gather pertinent clinical information?

Questions for Abdominal Exams

<table>
<thead>
<tr>
<th>Abdominal Pain:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask about specific site of pain (quadrant, generalized, epigastric, periumbilical, etc.)</td>
</tr>
<tr>
<td>Ask about context of pain (sudden, chronic, stabbing, colicky, after eating, etc.)</td>
</tr>
<tr>
<td>Ask about severity of pain (pain scale on 1 to 10. Ten being unbearable)</td>
</tr>
<tr>
<td>Ask about duration of pain</td>
</tr>
<tr>
<td>Ask if there was any injury or related possible cause of pain</td>
</tr>
<tr>
<td>Ask if there are any related signs or symptoms (GI/GU symptoms, rigidity, rebound, etc.)</td>
</tr>
<tr>
<td>Ask if there is any associated disease/condition (GI/GU condition, cancer, etc.)</td>
</tr>
</tbody>
</table>
The Radiology Technologist

The radiology technologists play a critical role in the process! They are the last link between the patient and the interpreting radiologist.

• They have clinical knowledge and can gather pertinent clinical information.

• Customer service! When you ask about the patient’s condition it makes the patient feel that you have their medical well-being at heart.

• Review the patient history form and ask for specific details that are missing.

• Good quality and pertinent medical information leads to better outcomes as the radiologist is better equipped to critically review the images.

• Training on ICD-10-CM for technologists is critical so that they understand what is needed!

The Radiologist

By design, radiologists have to rely on referring physicians and others for clinical information about the patient. However, radiologists must document all pertinent positive findings.

• It will be the radiologist’s responsibility to capture required details for positive findings.

• Radiologists cover a wide spectrum of clinical conditions in the scope of the services they provide.

• Education is a must!

• Coding tools will be important to their success.

• Audit now to provide feedback.
The Medical Coder

Codes selected for billing purposes must be supported by the medical record.

- Radiology coders typically do not have access to the patient’s electronic medical record.
- Radiology coders rely on the final dictated report to code and bill radiology services.
- Codes for signs and symptoms should not be reported with a confirmed diagnosis if the symptoms are integral to the diagnosis.
- Training is critical. Certified coders must spend time studying the guidelines.
- Productivity will suffer: Practice, practice, practice. If they do not spend significant time using the new code set claims will be delayed. Duel code over the next few months!

Where to Find Missing Clinical Data?

- Order or Scheduling management systems
- Patient medical records
- RIS or PACS for clinical history
- DICOM header tags
- Queries to the radiologists
- Queries to the facility performing the technical component
- Queries to the ordering physician
Common Risks in Radiology

• Pain
  – Specific anatomical location
  – Severity or pain scale
  – Context (stabbing, with breathing, with activity)
  – Duration (onset, frequency)
  – Associated disease or condition
  – Related possible cause

• Injury
  – Timing:
    ▪ During diagnostic or active treatment phase
    ▪ During healing phase, or
    ▪ Due to complication after end of treatment
  – What type of injury? (animal bite, contusion, laceration)
  – What anatomical area is involved?
  – Are there other associated symptoms? (foreign body, closed or open fracture, unconsciousness)

These common indications result in non-billable or denied services!
Common Risks in Radiology

• Fall (also see MVA)
  – Repeated falls
  – History of falling

• Motor Vehicle Accident (MVA)
  – What type of injury was sustained?
  – What part of the body was injured?
  – What symptoms is the patient experiencing?
  – Is the patient conscious?
  – Where and how?
  – Timing (during active treatment, during healing phase, or complication)

• Rule out, probable, suspicious

• Pre-operative screening
  – Does the patient have a medical condition that increases intraoperative risk?
  – What type of surgery? Is it a cardiovascular or pulmonary procedure?

Capturing Details about Pain

<table>
<thead>
<tr>
<th>Chest Pain:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document specific site of pain (chest wall, intercostal, precordial, rt/lt sided, etc.)</td>
</tr>
<tr>
<td>Document context of pain (sudden, stabbing, with breathing, etc.)</td>
</tr>
<tr>
<td>Document severity of pain (pain scale)</td>
</tr>
<tr>
<td>Document duration of pain</td>
</tr>
<tr>
<td>Document any injury or related possible cause of pain</td>
</tr>
<tr>
<td>Document any related signs or symptoms (chest tightness, SOB, arm pain, etc.)</td>
</tr>
<tr>
<td>Document any associated disease/condition (COPD, cancer, etc.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Abdominal Pain:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document specific site of pain (quadrant, epigastric, generalized, periumbilical, etc.)</td>
</tr>
<tr>
<td>Document context of pain (sudden, chronic, stabbing, colicky, after eating, etc.)</td>
</tr>
<tr>
<td>Document severity of pain (pain scale)</td>
</tr>
<tr>
<td>Document duration of pain</td>
</tr>
<tr>
<td>Document any injury or related possible cause of pain</td>
</tr>
<tr>
<td>Document any related signs or symptoms (GI/GU symptoms, rigidity, rebound, etc.)</td>
</tr>
<tr>
<td>Document any associated disease/condition (GI/GU condition, cancer, etc.)</td>
</tr>
</tbody>
</table>
Capturing Details about Pain

<table>
<thead>
<tr>
<th>Limb Pain:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Document specific site of pain (RT/LT, upper/lower, site specific on arm/leg, etc.)</td>
<td></td>
</tr>
<tr>
<td>Document context of pain (sudden, at rest/exercise, radiating, etc.)</td>
<td></td>
</tr>
<tr>
<td>Document severity of pain (pain scale)</td>
<td></td>
</tr>
<tr>
<td>Document duration of pain</td>
<td></td>
</tr>
<tr>
<td>Document any injury or related possible cause of pain</td>
<td></td>
</tr>
<tr>
<td>Document any related signs or symptoms (numbness, cyanosis, tingling, etc.)</td>
<td></td>
</tr>
<tr>
<td>Document any associated disease/condition (arthritis, pathologic fractures, cancer, etc.)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Headache:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Document specific site of pain (frontal, temporal, facial, etc.)</td>
<td></td>
</tr>
<tr>
<td>Document context of pain (sudden, tension, cluster, migraine, throbbing, chronic, etc.)</td>
<td></td>
</tr>
<tr>
<td>Document severity of pain (pain scale)</td>
<td></td>
</tr>
<tr>
<td>Document duration of pain</td>
<td></td>
</tr>
<tr>
<td>Document any injury or related possible cause of pain</td>
<td></td>
</tr>
<tr>
<td>Document any related signs or symptoms (vision changes, sinusitis, etc.)</td>
<td></td>
</tr>
<tr>
<td>Document any associated disease/condition (neurologic condition, sinus, cancer, etc.)</td>
<td></td>
</tr>
</tbody>
</table>

Fractures: Documentation Tips and Classifications

<table>
<thead>
<tr>
<th>DOCUMENTATION FOR FRACTURES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Traumatic fracture</td>
<td>Pathological fracture</td>
</tr>
<tr>
<td>Anatomical location: (e.g. shaft, sternal end)</td>
<td>Underlying cause (neoplastic or osteoporosis)</td>
</tr>
<tr>
<td>Laterality: Right, Left, or Bilateral</td>
<td>What type of cancer?</td>
</tr>
<tr>
<td>Displaced or nondisplaced?</td>
<td>What type of osteoporosis? (e.g. age-related, idiopathic, drug-induced)</td>
</tr>
<tr>
<td>Type of fracture (e.g. Greenstick, oblique, spiral, comminuted)</td>
<td>Anatomical Location - which bone</td>
</tr>
<tr>
<td>Open or closed fracture?</td>
<td>Laterality (right, left, bilateral)</td>
</tr>
<tr>
<td>Episode of care (Initial, subsequent, or sequel)</td>
<td>Subsequent radiology exams, indicate one of the below:</td>
</tr>
<tr>
<td>Type I - Wound less than 1 cm with minimal soft tissue injury</td>
<td>- Routine healing</td>
</tr>
<tr>
<td>Type II - Wound greater than 1 cm with moderate soft tissue injury</td>
<td>- Delayed healing</td>
</tr>
<tr>
<td>Type III - Extensive damage to soft tissue</td>
<td>- Nonunion</td>
</tr>
<tr>
<td>Malunion</td>
<td></td>
</tr>
</tbody>
</table>

Anderson and D’Alonzo Classification (DENs Fractures)

| Type I - Oblique avulsion fracture of tip of odontoid. Due to avulsion of alar ligament. |  |
| Type II - Fracture through waist (high nonunion rate due to interruption of blood supply) |  |
| Type III - Fracture extends into cancellous body of C2 & involves a variable portion of the C1-C2 joint. |  |
Grading Vertebral Injury: Spondylolisthesis

Spondylolisthesis is graded according to the degree that one vertebral body has slipped forward on another.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Less than 25 percent slip</td>
</tr>
<tr>
<td>II</td>
<td>Between 25 and 50 percent slip</td>
</tr>
<tr>
<td>III</td>
<td>Between 50 and 75 percent slip</td>
</tr>
<tr>
<td>IV</td>
<td>More than 75 percent slip</td>
</tr>
<tr>
<td>V</td>
<td>Upper vertebral body has slid all the way forward off the front of the lower vertebral body. Very rare.</td>
</tr>
</tbody>
</table>

Asthma: Documentation Guidelines for Severity

### ASTHMA SEVERITY CHART

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>INTERMITTENT</th>
<th>MILD PERSISTENT</th>
<th>MODERATE PERSISTENT</th>
<th>SEVERE PERSISTENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 or less days per week</td>
<td>More than 2 days per week</td>
<td>Daily</td>
<td>Throughout the day</td>
<td></td>
</tr>
<tr>
<td>2 x’s per month or less</td>
<td>3 – 4 x’s per month</td>
<td>More than once per week but not nightly</td>
<td>Nightly</td>
<td></td>
</tr>
<tr>
<td>2 or less days per week</td>
<td>More than 2 days per week, but not daily</td>
<td>Daily</td>
<td>Several times per day</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>Minor limitation</td>
<td>Some limitation</td>
<td>Extremely limited</td>
<td></td>
</tr>
<tr>
<td>FEV1&gt;80% predicted and normal between exacerbations</td>
<td>FEV1&gt;80% predicted</td>
<td>FEV1 60 – 80% predicted</td>
<td>FEV1 less than 60% predicted</td>
<td></td>
</tr>
</tbody>
</table>
Other Classifications and Staging Tools

National Kidney Foundation KDOQI Stages of Chronic Kidney Disease:

<table>
<thead>
<tr>
<th>CKD Stage</th>
<th>Description</th>
<th>GFR level (mL/min/1.73 m²)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>Signs of mild kidney disease with normal GFR</td>
<td>≥ 90</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Mild kidney disease with reduced GFR</td>
<td>60-89</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Moderate chronic renal insufficiency</td>
<td>30-59</td>
</tr>
<tr>
<td>Stage 4</td>
<td>Severely reduced kidney function</td>
<td>15-29</td>
</tr>
<tr>
<td>Stage 5</td>
<td>Very severe, or endstage kidney function</td>
<td>&lt;15</td>
</tr>
</tbody>
</table>

Body Mass Index (BMI)

<table>
<thead>
<tr>
<th>BMI Type</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>Below 18.5</td>
</tr>
<tr>
<td>Normal</td>
<td>18.5-24.9</td>
</tr>
<tr>
<td>Overweight</td>
<td>25.0-29.9</td>
</tr>
<tr>
<td>Obesity</td>
<td>30.0 and above</td>
</tr>
</tbody>
</table>

Documenting Ulcers

Pressure Ulcer Stages

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>Skin changes limited to persistent local edema</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Abrasion, blister, partial thickness skin loss involving epidermis and/or dermis</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Full thickness skin loss involving damage or necrosis if subcutaneous tissue</td>
</tr>
<tr>
<td>Stage 4</td>
<td>With necrosis of soft tissues through to underlying muscle, tendon, or bone</td>
</tr>
<tr>
<td>Unstageable</td>
<td>Example: the ulcer is covered by eschar, treated with a skin or muscle graft, or documented as deep tissue injury but not documented as due to trauma.</td>
</tr>
</tbody>
</table>

NOTE: Document the site of the ulcer and laterality when it applies. Document and code first any associated gangrene.

Non-Pressure Ulcers Severity

<table>
<thead>
<tr>
<th>Severity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited to breakdown of skin</td>
<td></td>
</tr>
<tr>
<td>Fat layer exposed</td>
<td></td>
</tr>
<tr>
<td>Necrosis of muscle</td>
<td></td>
</tr>
<tr>
<td>Necrosis of bone</td>
<td></td>
</tr>
</tbody>
</table>

NOTE: Document the site of the ulcer and laterality when it applies. Document and code first any associated gangrene. Document and code first associated underlying conditions:

- Atherosclerosis of the lower extremity
- Chronic venous hypertension
- Diabetic ulcers
- Postthrombotic syndrome
- Postthrombotic syndrome
- Varicose ulcer
Pregnancy Studies

<table>
<thead>
<tr>
<th>Trimester Designation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Trimester</td>
<td>Less than 14 weeks 0 days</td>
</tr>
<tr>
<td>Second Trimester</td>
<td>14 weeks 0 days to less than 28 weeks 0 days</td>
</tr>
<tr>
<td>Third Trimester</td>
<td>28 weeks 0 days until delivery</td>
</tr>
</tbody>
</table>

**NOTE:** Trimesters and gestational age are counted from the first day of the last menstrual period.

<table>
<thead>
<tr>
<th>7th Character Extender to Designate Fetus Involved in the Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not applicable or unspecified</td>
</tr>
<tr>
<td>1</td>
<td>Fetus 1</td>
</tr>
<tr>
<td>2</td>
<td>Fetus 2</td>
</tr>
<tr>
<td>3</td>
<td>Fetus 3</td>
</tr>
<tr>
<td>4</td>
<td>Fetus 4</td>
</tr>
<tr>
<td>5</td>
<td>Fetus 5</td>
</tr>
<tr>
<td>9</td>
<td>Other fetus</td>
</tr>
</tbody>
</table>

Gestational age must be documented/calculated to select appropriate codes
Gestational Age Calculator - [http://www.perinatology.com/calculators/Due-Date.htm](http://www.perinatology.com/calculators/Due-Date.htm)

**Resources**


- American Academy of Professional Coders Resources (AAPC) website: [http://www.aapc.com](http://www.aapc.com)
Thank You

Please submit questions using Chat.

Answers, with supporting resources, will be posted on the webinar series webpage:

http://webinars.vrad.com/reimbursement_series

vRad team members with specific scenarios or questions are encouraged to contact Sharon Roeder for further support.